



Texas Department of Insurance

Division of Workers' Comp

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

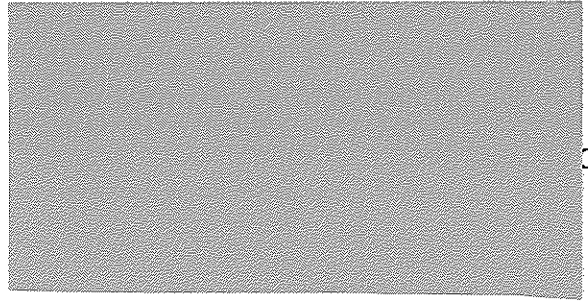
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

SOLANO ANESTHESIA CONSULTANTS INC
PO BOX 7096
STOCKTON CA 95267



Respondent Name

Texas Mutual Insurance Company

Carrier's Austin Representative Box

Box Number 54

MFDR Tracking Number

M4-11-2984-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "...We originally billed the claim to Texas Mutual and they have denied the claim stating that we are past their timely filing criteria for the State of Texas. However, the services were not provided in the State of Texas. They were provided in the State of California. There is no such law in the State of California that we have to bill a claim within 95 days from the date of service..."

Amount in Dispute: \$850.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "1. The requestor provided anesthesia services to the claimant on 9/17/10. (see requestor's DWC-60 packet.) 2. Texas Mutual received the bill 1/6/11. (Attachment) Texas Mutual denied payment because the bill was late. (see DWC Rule 133.20.)...No payment is due."

Response Submitted by: Texas Mutual Insurance Company, 6210 E Hwy 290; Austin TX 78723

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 17, 2010	01830 P3 (Anesthesia Open Radius)	\$850.00	\$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for health care providers to pursue a medical fee dispute.

2. 28 Texas Administrative Code §133.20 and Texas Labor Code §408.027 set out the procedures for health care providers to submit workers' compensation medical bills for reimbursement.

3. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits dated January 18, 2011

- CAC-29 The time limit for filing has expired
- 731 Per 133.20 provider shall not submit a medical bill later than the 95th day after the date THE [sic] of service, for services on or after 9/1/05

Explanation of benefits dated March 15, 2011

- CAC-193 Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- CAC-29 The time limit for filing has expired
- 724 No additional payment after a reconsideration of services. For information call 1-800-937-6824
- 731 Per 133.20 provider shall not submit a medical bill later than the 95th day after the date the [sic] service, for services on or after 9/1/05

Issues

1. Under what authority is a request for medical fee dispute resolution considered?
2. Did the requestor submit the medical bill for the services in dispute timely and in accordance with 28 Texas Administrative Code §133.20 and Texas Labor Code §408.027?
3. Is the requestor entitled to reimbursement?

Findings

1. The requestor provided anesthesia services in the state of California on September 17, 2010 to an injured employee with an existing Texas Workers' Compensation claim. The requestor was dissatisfied with the respondent's final action. The requestor filed for reconsideration and was denied payment after reconsideration. Then, the requestor filed for dispute resolution under 28 Texas Administrative Code §133.307. The Division concludes that because the requestor sought the administrative remedy outlined in 28 Texas Administrative Code §133.307 for resolution of the matter of non-payment, the dispute is to be decided under the jurisdiction of the Texas Workers' Compensation Act and applicable rules.
2. The Texas Workers' Compensation Act, 28 Texas Administrative Code §133.20 and Texas Labor Code §408.027 requires health care providers, with few exceptions, to submit a medical bill not later than the 95th day after the date of service is provided. No documentation was found to support that the medical bill for the service in dispute was filed timely, nor was documentation submitted to support that the medical bill in dispute fell under the exceptions for timely filing described in 28 Texas Administrative Code §133.20(b) and Texas Labor Code §408.0272.
3. The requestor failed to timely submit the medical bill for the services in dispute. Therefore, in accordance with Texas Labor Code §408.027(a), the requestor has forfeited its right to reimbursement.

Conclusion

For the reasons stated above, the division finds that the requestor has not established that reimbursement is due. As a result, the amount ordered is \$0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the disputed services.

Authorized Signature

September 26 2011

Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within twenty days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with other required information specified in Division rule at 28 Texas Administrative Code §148.3(c).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.

